

Groupwork 20(1), 2010, pp.63-86. © W&B, 2010. DOI: 10.1921/095182410X535935

Strengths-based groupwork with alcohol dependent older persons: Solution to an age-old problem?

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Abstract: Worldwide the numbers of older people in the population are increasing. Simultaneously the need for treatment programmes increases as more alcohol dependent people are growing into old age. Literature reviews revealed that groupwork programmes offered to older persons are exclusively problem-centred, while strengths-based scholars suggest that following a strengths perspective may be more effective. The majority of studies tend to evaluate the outcomes of treatment programmes quantitatively. It was also found that South Africa, which adopted a developmental approach towards social welfare, lacks groupwork programmes specifically designed for alcohol dependent older persons. This article reports on the outcomes of a strengths-based groupwork programme for alcohol dependent older persons. The programme is unique in the sense that it is based on a strengths perspective; it is reconcilable with South Africa's welfare approach; and follows a mixed methods research approach in order to evaluate the programme holistically. Eight respondents were randomly selected. The results, collected with a group administered questionnaire, show that the respondents' psychosocial functioning improved, in that: their repertoire of strengths increased and they have achieved, or are on a path towards, ego integrity. This programme is considered to be complementary to current treatment programmes.

Key words: strengths perspective; ego integrity; groupwork; older persons; alcohol dependency; mixed methods research

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Introduction

Worldwide an increase in the numbers of older people in the population is occurring (Hooyman and Kiyak, 2008). Simultaneously, more and more alcohol dependent people are growing into old age (Van Wormer & Davis, 2008; Gfroerer, Penne, Pemberton, & Folsom, 2003). *Census 2001* (Statistics South Africa, 2005) estimated the numbers of the South African older population as follows: 1.2 million (10.3%) between 55-59, 1.1 million (9.1%) between 60-64 and 2.2 million (4.9%) 65 years or older. Not surprisingly South African statistics show an increase in alcohol dependency amongst older persons (cf. Parry, 2000). Parry, Plüddemann, Steyn, Bradshaw, Norman and Laubscher (2005) estimate that 27.6% of males and 9.6% females between the ages of 55-64 could be identified as people who abuse alcohol. Of people 65 years and older the estimations are that 20.3% of males and 12.2% of females are abusing alcohol. These statistics indicate the prevalence of alcohol abuse amongst older persons in a developing country. Unfortunately, alcohol dependency amongst older persons is also on the increase in developed countries. In 2001 it was estimated that 1.7 million older persons in the United States of America (USA) needed substance abuse treatment, while a rise to 4.4 million is expected by 2020 (Cummings, Bride, Cassie & Rawlins-Shaw, 2008). The same authors refer to the *Epidemiologic Catchment's Area (ECA) Study* which found the '... prevalence rates of alcohol abuse ... to be 1.9% ... for older men and 0.4% ... for older women ...' Although these statistics are only representative of one developed and one developing country, they show that alcohol abuse amongst older persons is exceptionally high and expected to increase in the future. It thus seems that alcohol abuse is most probably a worldwide phenomenon amongst older persons which requires urgent attention from social welfare service providers, such as social workers, to prevent and treat alcohol dependency. Cummings et al. (2008, p. 217) contextualise the situation amongst older persons as follows:

As the population continues to age, social work practitioners and researchers will increasingly confront the needs of older adults with substance abuse disorders. The ability of the social work profession to respond to these needs is dependent upon the development of strategies effective for use with the older populations and upon social work professionals' knowledge of such strategies.

Before the outcomes of the programme are discussed, the researcher believes it is imperative to contextualise the programme within (a) the South African social welfare context, and (b) international trends in the treatment of this social problem.

The South African social welfare context

In 1994 the democratically elected African National Congress (ANC) came into power. Their manifesto, the *White Paper on Reconstruction and Development* (RSA, 1994), paved the way for the welfare sector to adopt a developmental social welfare paradigm with the aim ‘... to promote social justice ... build human capabilities and enhance livelihoods and social functioning ...’ (Patel, 2005, p. 208). Through the *White Paper for Social Welfare* (hereafter referred to as the White Paper) the social welfare sector was restructured from a predominantly residual model to a development model (RSA, Ministry of Welfare and Population Development, 1997). Consequently social workers in South Africa needed to adopt a developmental approach towards social service delivery and this resulted in the expansion of the field of developmental social work (Patel, 2005; Gray, 2002). One of the practice perspectives used to implement developmental social work is the strengths perspective (Geyer and Strydom, 2007; Gray, 2002). With a strengths perspective ‘The emphasis shifts from problems and deficits defined by the worker to possibilities and strengths identified in egalitarian, collaborative relationships with clients’ (Blundo, 2009, p. 39), because

Strengths-based practitioners believe that no matter how dismal the circumstances, people have possibilities, resiliencies, and capacities for change and even transformation. (Van Wormer & Davis, 2008, p. 86)

The strengths perspective

Weick, Rapp, Sullivan and Kisthardt (1989, p. 350) eloquently capture the essence of the strengths perspective when they state that

The strengths perspective is an alternative to a preoccupation with negative aspects of people and society and a more apt expression of some of the deepest values in social work.’

As the strengths perspective is a practice perspective (cf. Saleebey, 2009a; Rishty, 2000), it lacks an intervention process or practice model. Therefore, Kirst-Ashman (2007), Norman (2000) and Miley, O'Meila and DuBois (2001) propose that it is executed through either an empowerment process or resiliency enhancement. In addition, scholars of the strengths perspective propose that interviewing techniques of *solution-focused brief therapy* are utilised when working from a strengths perspective because it promotes the identification of clients' strengths (Weick, Kreider & Chamberlain, 2009; Van Wormer & Davis, 2008).

However, operating from a strengths perspective is not just about adding a 'strengths dimension' to service delivery. It requires an adoption of specific principles according to which services are offered. The following are the guiding principles of the strengths perspective (cf. Kisthardt, 2009; Nelson-Becker, Chapin & Fast, 2009; Saleebey, 2009a; Rapp, 2002; Murphy & Pardeck, 1998):

- Every individual, group, family and community has strengths, irrespective of their age and under all conditions.
- The helping relationship is characterised by collaboration and partnership.
- Social problems, such as alcohol dependency, may be troublesome, but should be considered sources of challenges and opportunities.
- The initial focus of the intervention process is on the strengths, abilities, talents and capabilities of service users, and not on diagnoses, deficits, symptoms and weaknesses.
- Every person has the capacity to grow, change and develop.
- Neither the social worker, nor the service user should put limits on the capacity of a person to grow and change. Therefore, the aspirations of service users should be taken seriously. Older persons may have aspirations they still want to accomplish.
- The social worker accepts the service users' opinion regarding their needs, challenges and strengths in order to cultivate ownership of their circumstances and to motivate them to handle it.

McCollum and Trepper (in Kirst-Ashman, 2007, p. 312) contextualise the mentioned principles quite accurately within the field of substance abuse when they state that social workers 'should find ways to recognize the strengths and abilities that clients bring with them to treatment and

not just focus on their liabilities.’ The programme reported on in this article is based on these principles.

Although the strengths perspective has been successfully implemented in the USA with diverse client groups, such as homeless people and persons with disabilities (Saleebey, 2009a; Moxley & Washington, 2001; Early & GlenMaye, 2000), its implementation with alcohol dependent older persons, specifically through groupwork services, has not yet materialised notwithstanding various claims in the literature that a strengths perspective could be more effective than the current dominating problem-centred approaches (Graybeal, 2001; Perkins and Tice, 1999; Rhodes and Johnson, 1996).

In South Africa, Geyer (2003) found that the majority of treatment programmes offered to older persons are in accordance with problem-centred approaches, e.g. cognitive behavioural therapy. Furthermore, Geyer (2003) found that those treatment centres which do take in older persons, implement one treatment programme for all their service users, irrespective of their age, although there are consistent pleas for specialised treatment for older persons aimed at their special needs and challenges (Barnea & Teichman, 1994; Widner & Zeichner, 1991). These findings are disappointing when it is taken into account that the White Paper specifically highlighted substance abuse as a social problem which needs priority attention (RSA, Ministry of Welfare and Population Development, 1997). In addition the *National Drug Master Plan 2006-2011*, as the South African strategy that ‘... reflects the country’s responses to the substance abuse problem ...’ (Department of Social Development, 2007, p. 4), identified older persons as a vulnerable group to whom special attention should be given to eradicate the abuse of substances.

As a result, the researcher took up the challenge to develop and evaluate a strengths-based groupwork programme for alcohol dependent older persons. The researcher specifically embarked on groupwork services because it is advantageous for older persons, e.g. older persons can improve their interpersonal skills while socialising within the safe environment of the group, the group could support group members to demonstrate their individual strengths during group sessions and motivate members to utilise those strengths outside the group, and group members usually voice their challenges and seek solutions in groups because it is believed that other group members have similar challenges (Toseland & Rivas, 2001; Toseland, 1995).

Through this study the researcher paid attention not only to a limitation within the sphere of international social work (Cummings et al., 2008), but also to a growing social problem in South Africa. It was envisaged that a strengths-based groupwork programme could make a contribution towards the management of alcohol dependency amongst older persons, while offering a practice initiative reconcilable with a developmental approach.

International trends in the treatment of alcohol dependency amongst older persons

According to Cummings et al. (2008), the majority of studies which evaluated the outcomes of treatment with older persons are quantitative in nature. As a consequence a more holistic understanding of the results of programmes is lost, because respondents are not afforded the opportunity to express their experiences qualitatively. With this study the researcher embarked on a mixed methods study in order to evaluate the outcomes of the programme from both a quantitative and qualitative paradigm to obtain results that are ‘... well-validated and substantiated ...’ (Creswell, 2009, p.213-214).

It is the aim of this article to report on the outcomes of a strengths-based groupwork programme for alcohol dependent older persons.

Research methods

The study was a component of a larger, predominantly quantitative, intervention research study. However, only the mixed-methods component is reported here. A mixed methods research approach (Creswell, 2009), was followed in this component of the research project to answer one research question, viz.: *Does a strengths-based groupwork programme with alcohol dependent older persons improve their psychosocial functioning?* Within the context of this study improved psychosocial functioning was determined with the following indicators (viz. dependent variables) which are discussed below.

- Respondents gain a repertoire of strengths. Strengths include, but are not limited to: what people learn about themselves, others and

their world as they struggle and cope with challenges; talents and skills; pride after rebound from obstacles; and spirituality (Saleebey, 2009a). Strengths also specifically include ‘... the skills we have developed’ (Miley et al., 2001, p. 205).

- Respondents’ narratives (qualitative feedback) resemble elements of ego integrity. Van Wormer & Davis (2008) are of the opinion that strengths-based intervention with substance abusing older persons should aspire towards the achievement of ego integrity. According to Erickson (in Hooyman & Kiyak, 2008), older persons experience optimal psychosocial functioning when they establish a sense of meaning in their life, characterised by peace and pride in their contributions and accomplishments, and accept themselves and their lives without despair.

The concurrent triangulation research design (Creswell, 2009) was employed to evaluate the outcome of the programme. A group administered questionnaire was completed by the individual group members before exposure to the programme (viz. the dependent variable), and three months after completion. Methodological triangulation, specifically between methods, was used to triangulate the quantitative and qualitative data which were concurrently collected with one data collection instrument at the pre-test and post-test level (Williamson, 2005). Both sets of data carried the same weight. The group administered questionnaire consisted of a Likert scale, for example ‘On a scale from zero to ten, how do you regard your attitude and knowledge regarding the following matters, before attending the groupwork programme (The scale is as follows: 0 is very bad, 5 is average, while 10 is excellent.)’ Apart from the quantitative data obtained, ‘What is different?’ questions were used as a form of open-ended questions which required qualitative feedback from respondents, e.g. ‘Since you have joined the group, what is different in your life?’ In order to determine whether the questionnaire was, on face value, a valid instrument, (Rubin & Babbie, 2010), it was scrutinised by three South African social work scholars. Means and concomitant standard deviations were calculated for quantifiable results, while the qualitative feedback was interpreted through content analysis. Eight (n=8) respondents were selected through simple random sampling who fitted the following criteria.

- Respondents were alcohol dependent elderly males (≥ 55 years);
- provided informed consent in writing; and,
- had received institutional care for at least six months to ensure completion of the programme and post-test measuring.

These criteria were deliberately applied for a number of reasons. Firstly, the number of respondents was limited to create a group atmosphere where the practitioner-researcher kept in touch with the experiences of individual group members in order to limit any form of harm (Toseland & Rivas, 2001). Furthermore, Rishty (2000) reasons that numbers should be limited when working with groups of older persons as this promotes the natural unfolding of the groupwork process. Secondly, the age limit of respondents had to be set at 55 years in order to be able to recruit eight respondents as no South African treatment centre had an adequate number of older alcohol dependent males and females at the time of the study. Nevertheless, the average age of respondents was 60 years at the time of the study and this age compares favourably with various international studies which evaluated substance abuse programmes for older persons with respondents as young as 45 years (cf. Kasher, Rodell, Ogden, Guggenheim & Karson, 1992, in Cummings et al., 2008). In addition, the researcher had to opt for implementing the programme with males only due to the absence of potential female respondents.

The eight respondents who participated in this study were selected from a population of 35 potential respondents. During the study the selected respondents only attended the strengths-based groupwork programme, while those in need of medical treatment, received medication for typical medical conditions related to older persons with a history of alcohol abuse, e.g. hypertension and diabetes. The researcher does not anticipate that any factor could contaminate the findings of this study as the other clients of the treatment centre attended the groupwork programme routinely offered by staff, while receiving medical treatment, if needed.

Ethical considerations such as informed written consent, no harm to respondents, as well as the maintenance of confidentiality, were applicable to this study (Babbie, 2007; Lewis, 2006; Strydom, 2005). The study was ethically cleared by the Ethics Committee of the North West University (Potchefstroom Campus, South Africa) before implementation.

Intervention process and content of groupwork programme

The researcher is of the opinion, that in order to understand the outcomes of the programme, a short description of the intervention process and programme content should be outlined.

Intervention process

This programme was implemented according to the empowerment process of Miley et al. (2001). Within the context of a strengths perspective, empowerment means to ‘... [assist] individuals, groups, families, and communities to discover and expand the resources and tools within them and around them’ (Saleebey, 1997, in Gutheil & Congress, 2000, p. 40). Table 1 overleaf depicts the process that was followed.

What follows is a synoptic description of the process. The *preparation phase* consisted of functional and emotional preparation. Functional preparation consisted of, amongst other things, a strengths-based assessment (Cowger and Snively, 2002; Kivnick and Murray, 2001) where the strengths and challenges of more than 50 alcohol dependent older persons were determined through interviews at treatment centres and self-help groups in four of the nine South African provinces. Based on the findings from these interviews, a thorough analysis of groupwork programmes offered at the time in South Africa, as well as literature studies on groupwork with older persons, the strengths perspective and alcohol treatment, the practitioner-researcher developed the strengths-based group work programme, while considering aspects such as group duration and frequency of sessions (for full details of the programme development process, see Geyer and Strydom, 2008). Furthermore, negotiations were started to gain entry to the research site. Emotional preparation consisted of personal preparation so as to attend to older persons in a genuine and empathetic manner.

During the *contact phase*, the researcher recruited respondents and informed them about the nature and scope of the proposed study and groupwork in general. In addition, informed written consent forms were signed. The first group meeting furthered the contact. The group started by establishing group rules and sharing mutual

Table 1
Intervention process

| Phase | Tasks within the phase |
|----------------|--|
| 1. Preparation | <ul style="list-style-type: none"> • Functional preparation • Emotional preparation |
| 2. Contact | <ul style="list-style-type: none"> • Partnership • Articulation of the situation • Preparation for facilitation |
| 3. Assessment | <ul style="list-style-type: none"> • Identify challenges • Identify strengths • Formulate an action plan |
| 4. Contract | <ul style="list-style-type: none"> • Goal formulation • Drafting a working agreement |
| 5. Action | <ul style="list-style-type: none"> • Solution-focused interviewing • Implementing working agreement |
| 6. Evaluation | <ul style="list-style-type: none"> • Evaluation of working agreement and tasks |
| 7. Termination | <ul style="list-style-type: none"> • Terminate with group members and handling of emotions |

expectations. The *assessment phase* included discussions about the themes to be discussed during the course of the programme. The group members received an opportunity to voice their challenges. Although the practitioner-researcher did not share the content of the proposed programme, the needs expressed by the group members were consistent with what the practitioner had planned. In order to identify the strengths of group members, a 'strengths questionnaire' of McQuaide and Ehrenreich (1997) was completed. It was agreed that eleven themes will be discussed, while making provision for group orientation and termination.

The group members and practitioner formulated the goal of the group and signed a working agreement similar to that proposed by Toseland and Rivas (2001), during the *contract phase*. Throughout the *action phase* the different themes were discussed whilst various groupwork media, i.e. role plays, music, questionnaires, informative presentations by a registered nurse (see session 9 and 10), as well as co-facilitation by a minister of religion during session 11, were employed. To ensure

that group members were continuously aware of, and utilised, their strengths, knew which resources to consult, and to acknowledge skills development, the practitioner made use of solution-focused interviewing.

The *evaluation phase* consisted of a group meeting where the practitioner and group members summarised the programme content, reflected on the groupwork process, the skills and strengths gained, and determined whether the programme addressed the members' challenges as envisaged. In conclusion the *termination phase* provided the group members and practitioner an opportunity to terminate by sharing their emotions verbally and in writing. At a closing ceremony each group member received a certificate as motivation to implement what they 'learned' through the programme.

To elaborate on the action phase, the content of the programme needs to be outlined.

Content of the programme

The goal of the programme was to improve the psychosocial functioning of alcohol dependent older persons through a strengths-based groupwork programme. Table 2 overleaf outlines the themes covered in the programme as well as the comprehensive objectives per group meeting.

In order to achieve the goal of the programme, it was spread over 13 group meetings on a weekly basis for 90 minutes per session. For a comprehensive exposition of the programme content, see Geyer and Strydom (2008).

Results

Although eight respondents were recruited for the study, only six (n=6) completed the programme. Diagram 1 depicts the quantitative results before and after exposure to the programme.

From Diagram 1 it is evident that, interpreted within a quantitative paradigm, respondents indicated an improvement in their attitude and knowledge in terms of all the themes after exposure to the programme. The discussion will corroborate that the qualitative findings echoed the

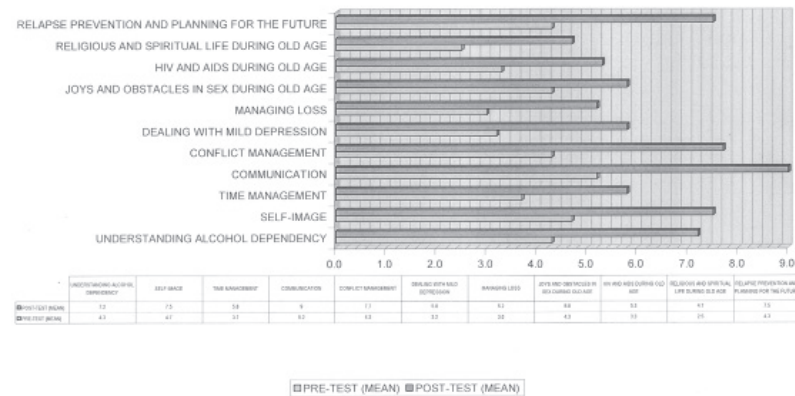
Table 2
Synopsis of programme content

| Theme of group meeting | Comprehensive objectives per group meeting |
|-------------------------------------|---|
| 1. First encounter and orientation | (a) To attend to the establishment of group relationships, (b) to discuss ethical considerations of social workers towards clients, (c) to discuss the principles of a strengths perspective and groupwork, (d) to confirm administrative aspects pertaining to programme implementation, (e) to contract with group members, and (f) to complete a group administered questionnaire prior to programme implementation. |
| 2. Understanding alcohol dependency | To facilitate alcohol dependent older persons in a process of acquiring the strength of knowledge regarding (a) alcohol dependency as a condition, (b) the causes and (c) consequences of alcohol abuse. |
| 3. Self-image | To facilitate alcohol dependent older persons in a process to identify their strengths through which they can improve their self-image. |
| 4. Time management | To facilitate a discussion on the skill of time management in order to learn, or refine it. |
| 5. Communication | To facilitate alcohol dependent older persons in order to (a) improve their knowledge and understanding of communication, and (b) participate in practical exercises to improve/refine their communication skills. |
| 6. Conflict management | To facilitate alcohol dependent older persons in a process to develop and improve/refine the strength of conflict management. |
| 7. Dealing with mild depression | To facilitate alcohol dependent older persons to develop and improve/refine the strength of constructive handling of mild (non-pathological) depression. |
| 8. Managing loss | To facilitate alcohol dependent older persons to develop and improve/refine the strength of managing loss as part of their journey to ego integrity. |

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|--|---|
| 9. Joys and obstacles in sex during old age | To facilitate alcohol dependent older persons to develop and improve the strength of comprehensive knowledge regarding (a) the joys of, and (b) obstacles to sex during old age. |
| 10. HIV and AIDS during old age | To facilitate alcohol dependent older persons to develop and improve the strength of comprehensive knowledge regarding HIV and AIDS in order (a) to prevent contraction of the disease or (b) to manage their lives successfully as HIV infected/affected people. |
| 11. Religious and spiritual life during old age | To facilitate alcohol dependent older persons in the exploration of religion and spirituality as possible strengths as these could help them on their journey to ego integrity. |
| 12. Relapse prevention and planning for the future | To facilitate a process where alcohol dependent older persons are, through a strength perspective, equipped (a) with knowledge and skills to prevent a relapse and (b) to formulate goals/objective for their future without alcohol use. |
| 13. Termination | To facilitate a process where alcohol dependent older persons reflect on the nature, content and extent of the groupwork programme. Furthermore, to receive a certificate in acknowledgement of their participation in the programme. |

DIAGRAM 1: PRE-TEST AND POST-TEST RESULTS



quantitative results.

On the question ‘Since you have joined the group, what is different in your life?’ five respondents provided positive feedback, such as ‘*More relaxed, less frustrated, more realistic, much greater acceptance of who and what I am . . .*’; ‘*Communication, self respect – I can manage my life better now*’; ‘*Not to worry about the past*’ and ‘*I have learned to be patient*.’ A respondent with ambivalent feelings responded as follows: ‘*Not very much*.’

Discussion

After orientation, the second meeting dealt with the theme, ‘Understanding alcohol dependency’, in order to ensure that respondents comprehended the impact of alcohol on their life and on the lives of others. Respondents indicated an increase from a mean of 4.3 (SD=1.8) to 7.2 (SD=2.2) regarding their attitude and knowledge about alcohol dependency. The positive change was confirmed with qualitative feedback such as ‘*I have a deeper knowledge of my problem*’ and ‘*I am no longer vulnerable to use alcohol for emotional reasons*.’

Alcohol dependent older persons are often exposed to stereotypes imposed upon them by the community. They also experience severe

feelings of guilt due to previous wrongdoing (Joubert, 2002). One aspect of optimal psychosocial functioning is a positive self-image. It was thus promising that the mean score for the theme 'self-image' increased from 4.7 (SD=1.9) to 7.5 (SD=1.9). Unfortunately, none of the respondents answered the open-ended question to qualitatively motivate the quantitative scores provided on the 10-point Likert scale. Based on the results it thus seems that the programme might have prompted older persons to reflect on their lives and identify positive aspects and consequently developed a more positive self-image.

Time management initially scored with a low of 3.7 (SD=2.1) and marginally increased to 5.8 (SD=1.9) at the post-test level. The qualitative feedback echoed the quantitative results with three respondents indicating a change in attitude and knowledge, for example *'Haven't even thought about it.'* These findings are discouraging, because it is a fact that progressively more older people need to remain active in the labour market, even after treatment for alcohol abuse, because the HIV/AIDS pandemic has deprived South Africa of sufficient numbers of adult employees (Strydom, Cronjé, Roux, Strydom and Wessels, 2005). Although time management may not be directly related to a strengths perspective, both the assessment prior to programme development and the group members confirmed a need to improve this skill because it was considered a challenge in their life. Irrespective of occupation, time management is undeniably a vital skill required to be an effective employee or to succeed in business, and to overcome boredom which might lead to alcohol use.

'Communication', verbal and non-verbal, was introduced as a theme as it forms the basis of relationships with significant others, colleagues, friends and the broader community (Alpaslan, 1994). Various scholars (cf. Torges, Stewart and Duncan, 2008; James and Zarrett, 2006) are in agreement that the skill of building relationships is important to achieve ego integrity during old age because communication indisputably forms the basis of any relationship. An increase from 5.2 (SD=2.9) to 9 (SD=0.9) for communication is considered a great improvement as it is a building block towards ego integrity. The improvement was unanimously confirmed with remarks such as *'Improved. I previously only thought about myself'* and *'Easier to communicate.'*

Conflict management is a skill which alcohol dependent people often lack, because the consequences of alcohol intake diminish competence

in this skill, especially towards marital/life partners (Jung, 1994). The mean score for conflict management had improved from 4.3 (SD=2.7) to 7.7 (SD=1.2). The qualitative feedback reiterated this finding with four of the respondents providing positive responses, e.g. *'Now I know much better who and what I am, and therefore I can manage conflict situations better.'* Conflict management is deemed a necessary life skill which all people should have in their repertoire of strengths because it enables people to be tolerant and accepting of others, promotes bio-psychological health when people deal adequately with conflict, whilst general satisfaction with life also increases. All these aspects, as captured in the narrative above, resemble ego integrity (James and Zarrett, 2006).

Older persons, especially those abusing alcohol, often suffer from depression (O'Connell, Chin, Cunningham and Lawlor, 2003; Menninger, 2002). Four respondents reasoned that the programme equipped them with skills to handle their negative feelings better. For example, one respondent wrote *'I talk to family and friends about my problems.'* This indicates a positive approach towards handling mild depression which could improve psychosocial functioning. Within the context of this study the concept 'mild depression' refers to feeling negative or down (cf. Kleinke, 1998). It does not refer to a psychological condition for which psychotherapy and medication are needed. The quantitative results confirmed the qualitative feedback, as an improvement from 3.2 (SD=1.6) to 5.8 (SD=1.9) was measured.

Older persons often need to deal with various forms of loss, e.g. the loss of life partners and significant others due to divorce or death, or of money as a consequence of bad financial decisions, of employment as a result of retrenchment, or of status after retirement (Benshoff and Koch, 2003; Joubert, 2002). Older persons may experience ego integrity once they have dealt with their losses as ego integrity includes the ability to adapt to disappointments and accept the course of life (Helm, 2000; Boylin, Gordon and Nehrke, 1976). An increase from 3 (SD=2.6) to 5.2 (SD=2.3) was measured for this skill. Three respondents explicitly indicated that the programme obligated them to deal with their losses. As a result remarks such as the following emerged: *'I am less rebellious and frustrated'* and *'I accept it.'* Other respondents honestly declared that they found it difficult to come to terms with their losses, i.e. *'I experience tremendous guilt.'* It thus seems that the respondents did not only start to deal with their losses but also communicate in narratives

reminiscent of ego integrity.

The meetings regarding 'The joys and obstacles in sex during old age' and 'HIV and AIDS during old age' were introduced to acknowledge that older persons have the need and ability to be sexually active, irrespective of age-related challenges, and the reality of HIV/AIDS (Crooks and Baur, 2002; Hillman, 2000). Respondents indicated that their attitude and knowledge regarding these issues had increased. Regarding sex during old age an increase from 4.3 (SD=2.9) to 5.8 (SD=3.4), and about HIV and AIDS from 3.3 (SD=3.1) to 5.3 (SD=4.4) were measured. Qualitative feedback confirmed the quantitative results. '*Safe sex only*' is representative of the feedback provided after the meetings. To change behaviour during old age is not easy. Therefore, the mere fact that respondents had indicated a willingness to be sexually responsible could mean that they were on the path to achieving ego integrity as they were concerned about their (sexual) health (James and Zarrett, 2006).

Pertaining to the theme 'Religious and spiritual life during old age', respondents indicated that their religious and spiritual lives had improved as reflected with a mean increasing from 2.5 (SD=1) to 4.7 (SD=3.3). Qualitative feedback declared that the group meeting had meaning for them, e.g. '*Thought about it*' and '*Improved to 90%*'. The researcher acknowledges that these constructs are problematic to measure (cf. Jackson and Cook, 2005) and that these findings were not substantiated with other measuring instruments. However, in line with the principles of a strengths perspective, the researcher deems the data provided to be the truth. Van Wormer and Davis (2008), Bowden (1998), as well as Koenig, George and Siegler (1988), are in agreement that alcohol dependent older persons have the need to establish a religious relationship with their Creator (thus not restricted to a certain religious belief) and should furthermore experience spirituality in order to recover from alcohol dependency. Both sets of data indicate that the programme might have encouraged respondents to attend to their religious and spiritual lives.

From a strengths perspective, relapse is considered normal in the healing process (Van Wormer and Davis, 2008). Therefore, the meeting on 'Relapse prevention and planning for the future' made an attempt to prevent relapses by equipping group members with skills to be resilient if a relapse occurs. A huge increase was measured for this skill, to be exact, from 4.3 (SD=1.8) to 7.5 (SD=1). The quote '*I am realistic*,

not idealistic’ is representative of the majority of qualitative feedback. Although these scores do not indicate an ability to prevent or manage relapses, they do indicate an attitudinal adjustment towards handling relapses. Relapse prevention is a critical strength to have as it has the potential to enable a person to rebound from obstacles, such as alcohol use, when it occurs (cf. Saleebey, 2009a).

If the definition and scope of strengths, as indicated before, are considered it seems that the programme succeeded in providing respondents with an opportunity to gain a repertoire of strengths. For example, respondents gained various skills which could be considered strengths, themes such as ‘self-image’ and ‘managing loss’ urged respondents to reflect and learn more about themselves and cope with their challenges, and respondents were of the opinion that they became more spiritual. Based on these results, the researcher concludes that the strengths-based programme succeeded in enhancing respondents’ repertoire of strengths.

Santor and Zuroff (1994) (in James and Zarrett, 2006, p 62) consider ego integrity as ‘(a) adapting to triumphs and disappointments; (b) spirituality; (c) acceptance of the course of one’s life and necessary; (d) tolerance or acceptance of other; (e) absence of death-anxiety; (g) freedom from the feeling, that time is running out; (h) emotional integration; and (i) satisfaction with life.’ These are also indicators of psychosocial well-being. Overwhelming positive responses were evoked by the question ‘Since you have joined the group, what is different in your life?’ Narratives, such as ‘*More relaxed, less frustrated, more realistic, much greater acceptance of who and what I am ...*’ bring the researcher to the conclusion that this programme enabled alcohol dependent older persons to achieve, or be on a path of reaching, ego integrity. The data obtained, and the discussion above, indicate that several of the indicators of ego integrity have been achieved by the respondents, i.e. adapting to disappointments, accepting the course of life, establishing (sound) relationships through communication and conflict management, as well as experiencing a general satisfaction with life.

Based on the quantitative and qualitative outcomes of this strengths-based programme, the conclusion is reached that this programme succeeds in improving the psychosocial functioning of alcohol dependent older persons. This is confirmed by the fact that: respondents’ repertoire of strengths increased and their feedback indicates that they

have either achieved, or are heading towards, ego integrity. However, the small number of respondents, the absence of a control group, and the fact that the group administered questionnaire is not standardised can be regarded as limitations of this study. Therefore, until more conclusive results are available, the researcher is of the opinion that this programme could be complementary to current treatment programmes aimed at alcohol dependent older persons. It could also be a reasonable alternative for follow up treatment to those clients who have relapsed and are re-admitted to treatment centres. Although the conclusions based on the outcomes are tentative, this programme has undeniably attended to an international need, while it is also reconcilable with South Africa's welfare approach.

Recommendations

This study is not without limitations and therefore a few recommendations for future research follows:

- The programme should be evaluated with an increased number of respondents, including a control group, while retaining a mixed methods research strategy.
- The outcome of the programme should be determined with alcohol dependent older persons who are situated within their communities and who are not institutionalised. This corresponds with a principle of the strengths perspective, namely that service users should be empowered in their natural environment and institutionalisation should be minimised (cf. Rapp, 1998).
- The programme should be presented to a women's group, as well as a group with both sexes. This will result in the evaluation of the programme in different situations.
- The group administered questionnaire should be repeatedly utilised, and adapted, in order to be standardised.
- Furthermore, scale developers need to consider the development and standardisation of strengths-orientated measuring instruments for diverse groups of service users. This will promote correlation studies between problem-centred and strengths-based practice initiatives in order to ascertain the success, or failure, of the

strengths perspective in various fields of service delivery. Currently there have been relatively few studies which have evaluated the strengths perspective through employing experimental designs (cf. Lietz, 2009; Saleebey, 2009b).

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